FINANCING HOSPITAL CARE THROUGH SOCIAL SECURITY*

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As a student of the Social Security program, my most useful contribution would be to talk about the financing of hospital insurance within the context of the Social Security program, which now pays for 37% of acute hospital care.

It is quite important that people interested in the retirement and disability portion of the Social Security Program start talking to the people who are interested in the hospital insurance program. Both groups rely on the same source to finance these programs, and the financial health of one has a significant impact on the ability of the other to draw on the payroll tax as a source of revenue.

As background, I shall briefly discuss the current status of Old Age Survivors and Disability Insurance financing in the wake of the 1983 amendments, then explore the outlook for the hospital insurance fund, and then comment on what I think should be kept in mind when considering ways to solve the Medicare dilemma.

THE OUTLOOK FOR OLD-AGE SURVIVORS AND DISABILITY INSURANCE (OASDI)

On April 20, 1983 President Reagan signed into law a massive Social Security financing package aimed at covering the immediate shortfall in revenues and eliminating the large deficits forecast after the turn of the century. For the short run, Congress enacted the bundle of tax increases, benefit reductions, and extensions of coverage that was recommended by the bipartisan National Commission on Social Security Reform. These changes also eliminated two thirds of the long term deficit. To eliminate the remainder of the long term deficit, Congress opted to increase the

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retirement age from 65 to 67.

The important question, of course, is whether the 1983 Social Security amendments have solved the problem for the OASDI portion of the program. And, along that line, I noticed an item in the *Boston Globe* (April 27, 1983) on Peter Peterson, chairman of Lehman Brothers, Kuhn, Loeb, Inc. He commented yesterday on the recent Social Security bailout, "If you believe that this Social Security program is going to solve the system's problems for at least 70 years, Lehman Brothers has at least two Brooklyn Bridges it would like to sell. Call 212-558-1500 in Manhattan." In trying to evaluate whether Peterson is right, it is useful to break the future down into three periods: the period between 1983 and 1989, the period from 1990 to about 2015, and then after 2015.

Under the intermediate assumptions used by the Social Security actuaries, the new legislation produces $166 billion in increased income and reduced expenditures during the 1983-1989 period. Even with the repayment of $12.4 billion in loans to the hospital insurance fund, these changes result in a steady buildup of the OASDI trust fund reserves so that balances will amount to 29% of annual outlays by the beginning of 1990.

Under more pessimistic economic assumptions, the legislation contributes $221 billion in added income and reduced outgo over the 1983-1989 period. Most of the additional amount over that produced under the intermediate assumptions is attributable to the revised indexing procedure, whereby benefits are adjusted by lowering increase of wages or prices when trust fund reserves are low. This provision reduces the cost-of-living adjustment by 3.5 percentage points in December 1984 and by a smaller amount in December 1985, and that is what leads to the greater reduction in outlays. These limitations produce positive, albeit quite low, levels of trust fund assets throughout the period. So it appears that under either the intermediate or the pessimistic economic assumptions, trust fund balances will be positive throughout the period from 1983 to 1989.

But we have had trouble before from economic projections that turned out to be significantly more optimistic than realistic. Therefore, it is useful to see whether the economic assumptions underlying the Social Security projections for the short term are consistent with those of private forecasters. I have looked at projections in Data Resources, Inc.* and Chase Econometrics,† which are two major private forecasting companies deal-

**Data Resources Review of the U.S. Economy*. Lexington, MA, Data Resources, Inc., 1983.
†*U.S. Macroeconomics Forecast and Analysis*. Bala Cynwyd, Pa., Chase Econometrics Assoc., Inc., 1983.

ing with the key economic variables. The first is the real wage differential, that is, the difference between the rate of increase in prices and the rate of increase in wages. Because the increase in wages determines how fast revenues grow and the rate of increase in prices determines how fast benefits are going to go up, the difference between the two variables is very important. The other important variable is the unemployment rate. When the Social Security actuaries' projections are compared with those of the private forecasters, we find the forecasters' projections fall between the intermediate and pessimistic assumptions. So, it seems the Social Security projections seem to be based on realistic economic assumptions. And I believe the 1983 amendments will carry us through 1990.

Once we reach 1990, the situation starts to brighten. We have a payroll tax increase and very favorable demographics during the next 15 years that produce a stable ratio of beneficiaries to workers. And, if we have any sort of productivity growth at all, we should have an enormous buildup in reserves. The actuaries estimate that by the year 2017 we should have reserves equal to 540% of annual outlays, an enormous sum of money. This accumulation of a large reserve is going to be the source of some problems.

In the long run, with the extension of the retirement age, the 1983 legislation brings the long run deficit almost to zero. There is still a deficit equal to .02% of taxable payrolls, but I think we need not worry about that. Remember that we are talking about deficits over a period of 75 years. That is the equivalent of somebody in 1908 making plans for today. So much can change over 75 years that it may be foolish making projections for that long a period, but I think that the Congress and the National Commission felt that for public relations reasons it is very important to have a long term deficit of approximately zero.

How realistic are the economic and demographic assumptions underlying the long run projections? It seems to me—but I know I am overshadowed here by the experts—that the long term fertility rate, which is really the key variable for the Social Security projections of 2.0, is probably realistic. This projection is quite similar to the Census Bureau's new intermediate or middle projection. The economic assumption, however, which assumes a real wage differential of 1.5, is the assumption I worry about. It means that we expect wages to go up over the long run faster than prices by 1.5% per year. This implies productivity growth in excess of 2%. That is somewhat higher than most economists are forecasting. But

what if we get a real wage differential of 1 instead of 1.5%? As it turns out, that would not be terrible since it would increase the long run deficit by 0.8%. Now that is a relatively small increase in the size of the deficit, but it has to be considered in terms of the overall size of the program. We now have a program that costs approximately 13% of taxable payrolls. If we introduce a deficit of 0.8% into the system, it turns out that the long-term deficit is only about 6% of the cost of the program. The rule of thumb, adopted by the Social Security trustees, is that when revenues are equal to plus or minus 5% of outlays, the system should be viewed in long run balance. So 6% percent is not anything to get upset about. In short, then, it seems that with a little luck (and "luck," I think, is becoming almost a technical term), the 1983 amendments should have restored relative balance to the OASDI program over the next 75 years.

The Outlook for Hospital Insurance

Having to come here today has forced me to look at the hospital insurance program. I have written books on Social Security that all start with the statement "I'm not going to address the issue of hospital insurance since the problems are totally different." Having looked at the hospital insurance program for two weeks, I feel reasonably well qualified to discuss the topic. Also, fortunately, Paul Ginsburg did a study on financing hospital insurance for the Congressional Budget Office which will provide a basis for most of my remarks.

Although the hospital insurance trust fund was a source of strength during the recent financial crisis, it faces serious financial problems in the near future. The balances in the Hospital Insurance trust fund increased steadily from 1966 through 1981, when the fund held $19 billion dollars in reserves. But substantial borrowing by the OASDI trust fund reduced that balance to $8 billion by the year-end of 1982. Now, with the favorable impact of the Social Security amendments, which did deal peripherally with hospital insurance, and repayment of borrowed funds, the resources should be sufficient to keep the trust fund healthy through 1988. But a large deficit in 1989 means that the trust fund will be exhausted by 1990. In the ensuing years, outlays will exceed income by widening margins and the deficits will grow rapidly. The Social Security actuaries project that cumulative deficits will equal $65 billion by 1992 under the intermediate assumptions, and $158 billion under the more pessimistic scenario. The Congressional Budget Office estimates that by

1995 the cumulative deficit will equal $310 billion, roughly twice the level of outlays in that year. Now, even for those of us who are old Social Security hands and used to talking about billions as if they are nothing, these are large sums. It is so much bigger than the problems that we have had facing the OASDI program that I find it mind-boggling. As Paul Ginsburg noted, the projected deficits are due to the fact that hospital costs are expected to increase much more rapidly than the wage base on which Hospital Insurance tax is levied. The Congressional Budget Office analysis shows hospital costs rising annually by 13.2% over the period 1982 and 1995 while covered earnings are projected to grow at only 6.8%. With a difference of 6.4% between the major determinants of outlays and the major determinants of income, deficits are not surprising.

After 1995, costs as a percentage of taxable payrolls are projected to increase steadily, which, with a tax rate fixed at 2.9%, produces ever increasing deficits. By 2006, the end of the period for which the Social Security actuaries make their official projections, costs are expected to exceed 7% of taxable payrolls, more than twice the scheduled Hospital Insurance tax rate. If projections are extended beyond 2006 on the assumption that hospital costs will rise at the same rate as wages, costs will eventually reach 11% of taxable payrolls under the intermediate assumption and stay at about that level through 2060. I agree with the many people with who argue, however, that extending the forecast beyond 25 years provides a misleading picture. It is really unreasonable to assume that unlimited growth in health care costs will be allowed to continue without some reform in our health care delivery system.

What can be done to restore a balance to the Hospital Insurance program? First, I think it is important to note, as Paul Ginsburg pointed out, that we have already done a great deal to try to restore the balance. In fact, as I see it, we have gone through all the tinkering we can do. We had the Omnibus Budget Reconciliation Act of 1981, which reduced outlays by about one billion dollars. We had The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), which expanded existing limits on reimbursement to include ancillary costs, established a three-year target reimbursement system, and extended Hospital Insurance coverage to federal employees. When fully phased in, the TEFRA reforms would reduce costs about $6 billion annually. Then we have the Social Security Amendments of 1983, which will fundamentally alter the way the government pays Medicare bills. As a result, the net impact of the 1983 amendments on Hospital Insurance income and outlays will be much larger than any of

the previous legislation. The saving from the prospective reimbursement system alone will gradually increase from a fraction of $1 billion in 1985 $7 billion by 1989. Over the entire period, 1983 to 1989, the new system should save about $18 billion dollars. The Hospital Insurance fund also profits from the increased tax rate for the self employed, which will raise revenues between now and 1990 by about $8 billion. The coverage of nonprofit employees will add another $3 billion. The total changes in the Hospital Insurance program from the 1983 amendments will amount to $34 billion between 1983 and 1989.

The crucial point is that we have done almost everything we can do, and even something as dramatic as the 1983 social security amendments only buys one more year. Morever, none of the changes contemplated even come close to solving the problem. To illustrate the magnitude of the changes required, the Congressional Budget Office study goes through an exercise that shows the size of the required change for specific proposals to restore balance to the program. For instance, the office looked at coinsurance. Now we can certainly reduce outlays by increasing the coinsurance amount, but the level of copayments required to maintain solvency over the period is substantially higher than those generally suggested. For example, the Reagan administration has proposed coinsurance for the second through the 15th day period of care equal to 8% of the deductible, and for the 16th through the 60th day of care equal to 5%. But, according to the budget office, to balance the program over the next 10 to 15 years we are talking about a coinsurance rate of 33%, not 5 or 8%. And if low income beneficiaries paid only a part of the copayment, the coinsurance amounts would have to be substantially higher. In any case, after 1995 these would have to increase steadily.

Another option the Congressional Budget Office considered is the possibility of solving the problem by raising the payroll tax. This does not bother me, but it would require a substantial hike. The combined employer/employee payroll tax would have to rise from 2.9 in 1986 to a level of 5.1% by 1995. That is a doubling for the Hospital Insurance payroll tax and I think that politicians would resist such a dramatic increase. The final option explored was an infusion of general revenues. Again, we are talking about a lot of money: $50 or $70 billion dollars a year by 1995.

In short, the additional revenues required to finance the hospital insurance portion of the Social Security program are substantially greater than those that were needed to restore solvency to the Old-Age Survivor's and Disability Income program. Because the cumulative projected deficits are

so large ($300 billion by 1995), maintaining financial balance in the next decade will require significant policy changes.

Some Fund Thoughts

Now what can we really do? I have learned enough in my two weeks of study of Hospital Insurance to know that obviously we are going to need changes outside the program to control the rapidly increasing costs of hospital care. If that is not done and the increase in hospital costs are not brought relatively in line with the increase in covered wages, the source of program revenues, then it will be impossible even to begin to stabilize the Hospital Insurance tax rate.

Cost control, however, is not going to happen fast, so we are probably going to face continued deficits. I would like to emphasize that we should not get trapped into the administration's view that the only alternative is to cut back the program. I think that we can afford higher taxes. Some cutbacks may be desirable, but higher payroll taxes should be a very real option. However, in all the discussions of financing social insurance programs, the problem has always been structured as one wherein revenues are fixed and the only option is to cut benefits to a level where they can be financed by the fixed revenues. In the Medicare discussions we want to be very careful that we view raising payroll taxes as a legitimate alternative. We can afford it. We are a rich country. Morever, the OASDI program is most likely under control. It will not need further infusions from the payroll tax in the foreseeable future, so increases in the payroll taxes are a viable means of financing hospital insurance.

The other consideration is that there is no reason that hospital insurance should be limited to the payroll tax. The payroll tax makes sense for the retirement and disability programs, where the benefits are more or less related to the money put in the system. For hospital insurance, however, the benefits depend on how sick the person becomes. Therefore, there is a good rationale, as suggested by many advisory councils, for financing a portion of the hospital insurance program from general revenues. I am partial to the proposal floating around to combine Parts A and B and to finance a portion of the combined program from general revenues.

My final point pertains to the fact that in tne 1990s there will be ample funds in the OASDI trust fund because of the increased tax rate and the favorable demographics. That money has got to stay there if the OASDI financing package that came out of the 1983 amendments is going to be

sufficient. But I just see it now, with large reserves in the OASDI trust funds and Hospital Insurance in bad shape. People are going to say, "Let's take a little from OASDI. After all, we did allow a little interfund borrowing in the 1980s, why not do it in a big way in the 1990s?" I feel very paternalistic—or maternalistic—about the OASDI program, I view it as my program. It is solidly financed and I really do not want hospital insurance people coming in and taking the revenues out of it. That is going to be the issue. Because I have decided that is going to be the main threat to the solvency of OASDI, I am going to have to devote some time trying to find some other way of solving the Medicare dilemma.